Sentinel Event Newsletter

Division of Licensing and Certification
Maine Department of Health and Human Services

Issue 28, June 2021

In This Issue

Analysis Shows Common Themes In Post-Discharge Suicide

In October, 2019, the Joint Commission conducted an analysis of 19 reported sentinel events related to suicide within 72 hours after discharge, some themes emerged:

- Almost all reported that a risk assessment was performed prior to discharge and most patients had an appointment scheduled for follow up or a recommendation for follow up care.
- The patients that were assessed at discharge were identified as low or moderate risk for suicide.
- Patients that were not assessed for suicide risk were usually admitted for a non-behavioral diagnosis.
- In all cases there was a triggering event that occurred after discharge, such as conflict with a family member, or a risk that was not identified, such as firearms at the residence, that led to or contributed to the patient's suicide.

Read full article here

ECRI Releases 2021 Survey of Patient Safety Concerns

ECRI has released the results its 2021 survey of patient safety concerns, and accompanying guidance.

The report finds that the top three areas of concern for patients are:

1. Racial and ethnic disparities in health care
2. Emergency preparedness and response in aging services
3. Pandemic preparedness across the health system.

Download ECRI's report here.

Maine Makes Top 10 in Rankings of ER Use by State

Becker's Healthcare published a review of data collected by Kaiser Family Foundation from American Hospital Association Annual Surveys between 1999-2019, and found that in 2019, Maine ranked 7th among the 50 US states in emergency room (ER) visits per capita.

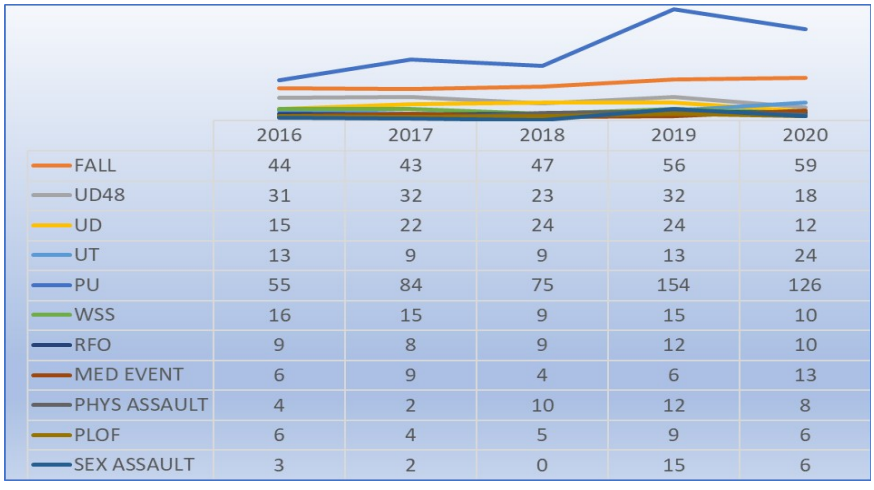
In 2019, the national ER visit rate was 437 per 1,000 residents, compared to Maine, which saw 537 ER visits, with New Hampshire close behind at 524 ER visits/1,000 people.

Read the full review here.

By the Numbers: State of Maine top sentinel events for the past 5 years

DLC staff recently performed an analysis of sentinel events that occurred in Maine over the past five years, and found:

- Pressure ulcers were the top reported event all 5 years
- Falls were the second highest reported event all 5 years
- The other events listed took turns where they placed in the top 5



	2016	2017	2018	2019	2020
FALL	44	43	47	56	59
UD48	31	32	23	32	18
UD	15	22	24	24	12
UT	13	9	9	13	24
PU	55	84	75	154	126
WSS	16	15	9	15	10
RFO	9	8	9	12	10
MED EVENT	6	9	4	6	13
PHYS ASSAULT	4	2	10	12	8
PLOF	6	4	5	9	6
SEX ASSAULT	3	2	0	15	6

Learning from Experience: Preventing pressure ulcers

DLC is sharing findings from recent root cause analysis' submitted by licensed health care facilities to provide information that Maine health care facilities have found useful in preventing sentinel events.

Preventing Pressure Ulcers

- Create a multidisciplinary process to standardize the care provided to patients with external fixators by developing a power plan for external fixators that includes mobility and skin care that are based on best practices for those devices
- Add daily management system boards to each nursing unit to ensure identification of safety issues, improve patient/family communication, improve staff-to-staff communication, and facilitate effective patient safety interventions
- Educate staff on Shrinker use: purpose of shrinker therapy, wear schedule, how to don/doff shrinker, skin checks

Rules Review: Developing thorough and credible root-cause analysis (RCA)

The State of Maine DHHS requires that root-cause analysis (RCA) for sentinel events must meet two essential standards of thoroughness and credibility. Details of these standards are included in the **Rules Governing the Reporting of Sentinel Events**, pages 13-14.

The relevant rules state:

4.3.4.3 Evidence of evaluation of the corrective actions implemented as a result of the similar event or events.

4.3.4.4 Evidence of communication with the receiving facility in the event of an inter-facility transfer.

4.3.4.5.1 Where improvement actions are planned, identification of who is responsible for Implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the action will be evaluated.

4.4.2.4 It includes the consideration of any relevant literature.

Sentinel Event Team
Jessica Levesque, Sentinel Event Program Manager
Elizabeth Church, R.N, Sentinel Event Clinical Specialist

Maine Department of Health and Human Services, *Jeanne Lambrew, Commissioner*
Division of Licensing and Certification
41 Anthony Avenue, Augusta, Maine 04333-0011 | 207-287-9300 | fax 207-287-3251 | https://www.maine.gov/dhhs/dlc